

Prostate, Lung, Colorectal and Ovarian Cancer Screening Trial

BASELINE QUESTIONNAIRE FOR FEMALE PARTICIPANTS (BQF3)

PLEASE COMPLETE:

Participant Name: _____
First Middle Last

Participant Date of Birth: _____
Month Day Year

Participant Telephone Number: () _____

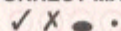
INSTRUCTIONS

- Do not fold, staple or tear the pages of this form.
- Use a #2 PENCIL to mark your answers.
- Make heavy black marks that fill the circle completely.
- If you need to change an answer, be sure to erase completely.
- Mark only one response for each question, unless the instructions tell you otherwise.
- Some questions ask you to write your answer in the space provided.
- Some questions also have additional instructions next to certain answers. These instructions may either ask you to skip questions that do not apply to you or ask you to provide additional information. First darken the appropriate circle, then follow the instructions as directed. Unless instructed otherwise, go to the next question.

CORRECT MARK



INCORRECT MARKS



STATEMENT OF CONFIDENTIALITY

Collection of this information is authorized by The Public Health Service Act, Section 412 (42 USC 285 a-1). Rights of study participants are protected by the Privacy Act of 1974. Participation is voluntary and there are no penalties for not participating or withdrawing from the study at any time. Participation will not influence a person's relationship with any provider of medical care or any federal program such as Social Security or Medicare. The information collected in this study will be kept confidential and will not be disclosed to anyone but the researchers conducting this study, except as otherwise required by law. Names and other identifiers will be separated from information provided and will not appear in any report of the study. Information provided will be combined for all study participants and reported as statistical summaries. Study records will be kept for approximately 2 years past the end of the study, and then destroyed.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0407). Do not return the completed form to this address.

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The following questions ask about your general background, work history, and smoking history.

1. In what state or foreign country were you born?

State/Foreign Country: _____

For Office
Use Only

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

2. Which of these groups best describes you?

☐ White ☐ Pacific Islander
☐ Black ☐ American Indian or
☐ Asian ☐ Alaskan Native

- 2a. Are you of Hispanic origin?

☐ No
☐ Yes

3. What is the highest grade or level of schooling you completed? (MARK ONLY ONE RESPONSE)

☐ Less than 8 years ☐ Some college
☐ 8 through 11 years ☐ College graduate
☐ 12 years or completed high school ☐ Postgraduate
☐ Post high school training other than college (for example, vocational or technical training)

4. What is your current marital status?

☐ Married or living as married ☐ Separated
☐ Widowed ☐ Never married
☐ Divorced

5. Which of these categories best describes your current working situation?

☐ Homemaker ☐ Extended sick leave
☐ Working ☐ Disabled
☐ Unemployed ☐ Other (SPECIFY) _____
☐ Retired

6. What has been your usual adult occupation? That is, at what type of occupation have you worked the longest during your adult life?

Usual adult occupation: _____

IF HOMEMAKER, GO TO QUESTION 10.

7. What were your usual activities and duties in this occupation?

Usual activities or duties: _____

8. In what type of business or industry were you usually employed in this occupation?

Business or industry: _____

9. How many years have you worked in this occupation?

_____ Number of years worked in occupation

10. Have you ever smoked cigarettes regularly for six months or longer?

☐ No (GO TO QUESTION 16)
☐ Yes

11. At what age did you start smoking cigarettes regularly? (Enter age first started smoking in the space provided, then darken the appropriate circles.)

Age In
Years:

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

12. Do you smoke cigarettes regularly now?

- ☐ No
☐ Yes (GO TO QUESTION 14)

13. At what age did you last stop smoking cigarettes regularly? (Enter age last stopped smoking in the space provided, then darken the appropriate circles.)

Age In
Years:

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

14. During periods when you smoked, how many cigarettes did or do you usually smoke per day?

- | | |
|-----------------------------|----------------------------------|
| <input type="radio"/> 1-10 | <input type="radio"/> 41-60 |
| <input type="radio"/> 11-20 | <input type="radio"/> 61-80 |
| <input type="radio"/> 21-30 | <input type="radio"/> 81 or more |
| <input type="radio"/> 31-40 | |

15. During periods when you smoked, did or do you more often smoke filter or non-filter cigarettes?

- ☐ Filter more often
☐ Non-filter more often
☐ Both about equally

16. Do you now or did you ever smoke a pipe regularly for a year or longer?

- ☐ Never smoked a pipe
☐ Did smoke a pipe but currently do not smoke
☐ Currently do smoke a pipe

17. Do you now or did you ever smoke cigars regularly for a year or longer?

- ☐ Never smoked cigars
☐ Did smoke cigars but currently do not smoke
☐ Currently do smoke cigars

The following questions ask about your family medical history and your personal medical history.

18. How many full and half-sisters do you have, both living and deceased?

- | | | | |
|-------------------------|-------------------------|-------------------------|----------------------------------|
| <input type="radio"/> 0 | <input type="radio"/> 3 | <input type="radio"/> 6 | <input type="radio"/> 9 |
| <input type="radio"/> 1 | <input type="radio"/> 4 | <input type="radio"/> 7 | <input type="radio"/> 10 |
| <input type="radio"/> 2 | <input type="radio"/> 5 | <input type="radio"/> 8 | <input type="radio"/> 11 or more |

19. How many full and half-brothers do you have, both living and deceased?

- | | | | |
|-------------------------|-------------------------|-------------------------|----------------------------------|
| <input type="radio"/> 0 | <input type="radio"/> 3 | <input type="radio"/> 6 | <input type="radio"/> 9 |
| <input type="radio"/> 1 | <input type="radio"/> 4 | <input type="radio"/> 7 | <input type="radio"/> 10 |
| <input type="radio"/> 2 | <input type="radio"/> 5 | <input type="radio"/> 8 | <input type="radio"/> 11 or more |

20. Have your parents, children, brothers, sisters, half-brothers, or half-sisters ever been diagnosed as having any type of cancer? (DO NOT INCLUDE BASAL-CELL SKIN CANCER)

- ☐ No (GO TO QUESTION 22)
☐ Yes

21. Please complete this chart for each relative (mother, father, children, brothers, sisters, half-brothers, half-sisters) diagnosed with cancer. (DO NOT INCLUDE BASAL-CELL SKIN CANCER.) (If you have more than four relatives diagnosed with cancer, please include a separate page with this information.)

Who was diagnosed as having cancer, that is, what is his or her relationship to you?	What type of cancer did he or she have?	How old was your relative when he or she was diagnosed as having cancer?
1st RELATIVE	Relationship	Type of cancer
2nd RELATIVE	Relationship	Type of cancer
3rd RELATIVE	Relationship	Type of cancer
4th RELATIVE	Relationship	Type of cancer

PLEASE DO NOT WRITE IN THIS AREA



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22. What is or was your weight at these ages?
(Enter the weight in pounds in the space provided, then darken the corresponding circles.)

Weight at Age 50?	Weight at Age 20? (Exclude weight during pregnancy.)	Current Weight?
<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2
<input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5	<input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5	<input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5
<input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8	<input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8	<input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8
<input type="radio"/> 9 <input type="radio"/> 0 <input type="radio"/> 1	<input type="radio"/> 9 <input type="radio"/> 0 <input type="radio"/> 1	<input type="radio"/> 9 <input type="radio"/> 0 <input type="radio"/> 1

23. How tall are you?
(Record your height in feet and inches in the space provided, then darken the appropriate circles.)

Feet	Inches
<input type="text"/>	<input type="text"/>
<input type="radio"/> 3	<input type="radio"/> 0
<input type="radio"/> 4	<input type="radio"/> 1
<input type="radio"/> 5	<input type="radio"/> 2
<input type="radio"/> 6	<input type="radio"/> 3
<input type="radio"/> 7	<input type="radio"/> 4
	<input type="radio"/> 5
	<input type="radio"/> 6
	<input type="radio"/> 7
	<input type="radio"/> 8
	<input type="radio"/> 9
	<input type="radio"/> 10
	<input type="radio"/> 11

24. During the last 12 months, have you regularly used aspirin or aspirin-containing products, such as Bayer, Bufferin, or Anacin? (Please do not include aspirin-free products such as Tylenol and Panadol.)
- ☐ No (GO TO QUESTION 26)
- ☐ Yes

25. During the last 12 months, how many pills of aspirin or aspirin-containing products did you usually take per day, per week, or per month?
- ☐ 1 per day ☐ 3-4 per week
- ☐ 2 or more per day ☐ Less than 2 per month
- ☐ 1 per week ☐ 2-3 per month
- ☐ 2 per week

26. During the last 12 months, have you regularly used ibuprofen-containing products, such as Advil, Nuprin, or Motrin?
- ☐ No (GO TO QUESTION 28)
- ☐ Yes

27. During the last 12 months, how many pills of ibuprofen-containing products did you usually take per day, per week, or per month?
- ☐ 1 per day ☐ 3-4 per week
- ☐ 2 or more per day ☐ Less than 2 per month
- ☐ 1 per week ☐ 2-3 per month
- ☐ 2 per week

28. Has a doctor ever told you that you have any of the following conditions? (MARK YES OR NO FOR EACH CONDITION)
- NO YES

- ☐ High blood pressure (hypertension)
- ☐ Coronary heart disease/heart attack
- ☐ Stroke
- ☐ Emphysema
- ☐ Chronic bronchitis
- ☐ Diabetes
- ☐ Colorectal polyp(s)
- ☐ Ulcerative colitis
- ☐ Crohn's Disease
- ☐ Familial polyposis
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Gardner's Syndrome
- ☐ Hepatitis
- ☐ Cirrhosis
- ☐ Diverticulitis/diverticulosis
- ☐ Gall bladder stones or inflammation

29. Have you ever been diagnosed as having cancer? (DO NOT INCLUDE BASAL-CELL SKIN CANCER)
- ☐ No (GO TO QUESTION 31)
- ☐ Yes

30. Please complete this chart for each cancer. (DO NOT INCLUDE BASAL-CELL SKIN CANCER.) (If you have been diagnosed with more than 3 types of cancer, please include a separate page to record this information.)

What type of cancer did you have?		How old were you when you were diagnosed with this cancer?
1st CANCER	Type of cancer	Age
2nd CANCER	Type of cancer	Age
3rd CANCER	Type of cancer	Age

31. How old were you when you had your first menstrual period?

- ☐ Less than 10 ☐ 14–15
☐ 10–11 ☐ 16 or older
☐ 12–13

32. How old were you when you had your last period?

- ☐ Less than 40 ☐ 50–54
☐ 40–44 ☐ 55 or older
☐ 45–49

33. Did your periods stop because of natural menopause, surgery, radiation, or drug therapy?

- ☐ Natural menopause ☐ Radiation
☐ Surgery ☐ Drug therapy

34. Have you ever tried to become pregnant for a year or more without success?

- ☐ No
☐ Yes

35. Have you ever been pregnant?

- ☐ No (GO TO QUESTION 43)
☐ Yes
☐ Don't know (GO TO QUESTION 43)

36. How old were you when you first became pregnant?

- ☐ Less than 15 ☐ 30–34
☐ 15–19 ☐ 35–39
☐ 20–24 ☐ 40–44
☐ 25–29 ☐ 45 or older

37. How many times have you been pregnant? Please include stillbirths, miscarriages, abortions, tubal or ectopic pregnancies, and live births.

- ☐ 1 ☐ 3–4
☐ 2 ☐ 5–9
☐ ☐ 10 or more

38. How many of your pregnancies resulted in a stillbirth?

- ☐ 0
☐ 1
☐ 2 or more

39. How many of your pregnancies resulted in a miscarriage or an abortion?

- ☐ 0
☐ 1
☐ 2 or more

40. How many of your pregnancies resulted in a pregnancy in one of your tubes, that is, a tubal or ectopic pregnancy?

- ☐ 0
☐ 1
☐ 2 or more

41. How many of your pregnancies resulted in a live birth? (If none, record "00" in the space provided, darken the corresponding circles, and go to Question 43.)

Pregnancies Resulting in a Live Birth

0	0
1	1
2	2
3	
4	
5	
6	
7	
8	
9	

42. What was your age at the birth of your first child?

- ☐ Less than 16 ☐ 30–34
☐ 16–19 ☐ 35–39
☐ 20–24 ☐ 40 or older
☐ 25–29

43. Did you ever take birth control pills for birth control or to regulate menstrual periods?

- ☐ No (GO TO QUESTION 46)
☐ Yes

44. How old were you when you first started taking birth control pills?

- ☐ Less than 30 ☐ 50–59
☐ 30–39 ☐ 60 or older
☐ 40–49

45. For how many total years did you take birth control pills?

- ☐ 10 years or more ☐ 2–3 years
☐ 6–9 years ☐ One year or less
☐ 4–5 years

46. Have you had a tubal ligation, that is, have you had your tubes tied?

- ☐ No
☐ Yes
☐ Don't know

47. Have you had a hysterectomy, that is, have you had your uterus or womb removed?
- ☐ No (GO TO QUESTION 49)
- ☐ Yes
- ☐ Don't know (GO TO QUESTION 49)
48. What was your age when you had your uterus or womb removed?
- ☐ Less than 40 ☐ 50–54
- ☐ 40–44 ☐ 55 or older
- ☐ 45–49
49. Have you ever had one or both of your ovaries removed?
- ☐ No (GO TO QUESTION 51)
- ☐ Yes
- ☐ Don't know (GO TO QUESTION 51)
50. What exactly was removed?
- ☐ One ovary–partial ☐ Both ovaries–total
- ☐ One ovary–total ☐ Don't know
- ☐ Both ovaries–partial
51. Sometimes women take female hormones such as estrogen or progesterone around the time of menopause. Have you ever used female hormones (tablets, pills, or creams) for menopause?
- ☐ No (GO TO QUESTION 54)
- ☐ Yes
- ☐ Don't know (GO TO QUESTION 54)
52. Are you currently using female hormones?
- ☐ No
- ☐ Yes
53. For how many total years did you take female hormones?
- ☐ 10 years or more ☐ 2–3 years
- ☐ 6–9 years ☐ One year or less
- ☐ 4–5 years
54. Have you ever been told by a doctor that you had any of the following conditions? (MARK YES OR NO FOR EACH CONDITION)
- | NO | YES |
|-----------------------|-----------------------|
| <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> |

55. During the past three years, have you had a chest x-ray?
- ☐ No ☐ Yes, more than once
- ☐ Yes, once ☐ Don't know
56. During the past three years, have you had a mammogram?
- ☐ No ☐ Yes, more than once
- ☐ Yes, once ☐ Don't know
57. During the past three years, have you had a pap smear?
- ☐ No ☐ Yes, more than once
- ☐ Yes, once ☐ Don't know
58. During the past three years, have you had a pelvic examination?
- ☐ No ☐ Yes, more than once
- ☐ Yes, once ☐ Don't know
59. During the past three years, have you had an ultrasound or scan of your ovaries?
- ☐ No ☐ Yes, more than once
- ☐ Yes, once ☐ Don't know
60. During the past three years, have you had a blood test for ovarian cancer, for example CA-125?
- ☐ No ☐ Yes, more than once
- ☐ Yes, once ☐ Don't know
61. During the past three years, have you had a test for blood in the stool?
- ☐ No ☐ Yes, more than once
- ☐ Yes, once ☐ Don't know

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62. During the past three years, have you had a colonoscopy, sigmoidoscopy, or barium enema to examine the colon and rectum?

- ☐ No ☐ Yes, more than once
☐ Yes, once ☐ Don't know

63. What is the date you completed this questionnaire?

Date of Completion

MONTH

- ☐ January
☐ February
☐ March
☐ April
☐ May
☐ June
☐ July
☐ August
☐ September
☐ October
☐ November
☐ December

DAY

0	0
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7	7
8	8
9	9

YEAR

0	0	0	0
1			1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9	9	9	9

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☐ Estimated Date

64. Who completed this questionnaire?

- ☐ Completed by study participant
☐ Completed by someone else (SPECIFY RELATIONSHIP)

Thank you very much for completing this questionnaire. Please check each page carefully to make certain you have answered all the questions that apply to you; then complete the Baseline Locator Form.

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SCREENING CENTER ID #

0	0
1	1
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6	6
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9	9

SATELLITE CENTER ID #

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

SC STAFF ID #

0	0	0	0
1	1	1	1
2	2	2	2
3	3	3	3
4	4	4	4
5	5	5	5
6	6	6	6
7	7	7	7
8	8	8	8
9	9	9	9

METHOD OF ADMINISTRATION

(MARK ONE):

- ☐ SELF-ADMINISTERED
☐ SELF-ADMINISTERED WITH ASSISTANCE
☐ IN-PERSON INTERVIEW BY SC STAFF
☐ IN-PERSON INTERVIEW BY OTHER (SPECIFY)
☐ TELEPHONE ADMINISTERED

FORM PROCESSING

(DARKEN CIRCLES AS STEPS ARE COMPLETED):

- ☐ Form Receipted into SMS
☐ Manual Review Completed

Data Retrieval:

- ☐ Attempted OR ☐ None Required

Data Entry of Non-Scannable Items:

- ☐ Completed OR ☐ None Required

Final Disposition:

- ☐ Final Complete (FCM) OR ☐ Final Incomplete (FIC)

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Item 21 Relationships with Cancer

SEQNO	RECODE	CACODE	AGE
1	0 0	0 0 0 0 0 0	
2	1 1	1 1 1 1 1 1	
3	2 2	2 2 2 2 2 2	
4	3	3 3 3 3 3 3	
5	4	4 4 4 4 4 4	
6	5	5 5 5 5 5 5	
7	6	6 6 6 6 6 6	
8	7	7 7 7 7 7 7	
	8 8	8 8 8 8 8 8	
	9 9	9 9 9 9 9 9	

SEQNO	RECODE	CACODE	AGE
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3	2 2	2 2 2 2 2 2	
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5	4	4 4 4 4 4 4	
6	5	5 5 5 5 5 5	
7	6	6 6 6 6 6 6	
8	7	7 7 7 7 7 7	
	8 8	8 8 8 8 8 8	
	9 9	9 9 9 9 9 9	

SEQNO	RECODE	CACODE	AGE
1	0 0	0 0 0 0 0 0	
2	1 1	1 1 1 1 1 1	
3	2 2	2 2 2 2 2 2	
4	3	3 3 3 3 3 3	
5	4	4 4 4 4 4 4	
6	5	5 5 5 5 5 5	
7	6	6 6 6 6 6 6	
8	7	7 7 7 7 7 7	
	8 8	8 8 8 8 8 8	
	9 9	9 9 9 9 9 9	

SEQNO	RECODE	CACODE	AGE
1	0 0	0 0 0 0 0 0	
2	1 1	1 1 1 1 1 1	
3	2 2	2 2 2 2 2 2	
4	3	3 3 3 3 3 3	
5	4	4 4 4 4 4 4	
6	5	5 5 5 5 5 5	
7	6	6 6 6 6 6 6	
8	7	7 7 7 7 7 7	
	8 8	8 8 8 8 8 8	
	9 9	9 9 9 9 9 9	

SEQNO	RECODE	CACODE	AGE
1	0 0	0 0 0 0 0 0	
2	1 1	1 1 1 1 1 1	
3	2 2	2 2 2 2 2 2	
4	3	3 3 3 3 3 3	
5	4	4 4 4 4 4 4	
6	5	5 5 5 5 5 5	
7	6	6 6 6 6 6 6	
8	7	7 7 7 7 7 7	
	8 8	8 8 8 8 8 8	
	9 9	9 9 9 9 9 9	

SEQNO	RECODE	CACODE	AGE
1	0 0	0 0 0 0 0 0	
2	1 1	1 1 1 1 1 1	
3	2 2	2 2 2 2 2 2	
4	3	3 3 3 3 3 3	
5	4	4 4 4 4 4 4	
6	5	5 5 5 5 5 5	
7	6	6 6 6 6 6 6	
8	7	7 7 7 7 7 7	
	8 8	8 8 8 8 8 8	
	9 9	9 9 9 9 9 9	

SEQNO	RECODE	CACODE	AGE
1	0 0	0 0 0 0 0 0	
2	1 1	1 1 1 1 1 1	
3	2 2	2 2 2 2 2 2	
4	3	3 3 3 3 3 3	
5	4	4 4 4 4 4 4	
6	5	5 5 5 5 5 5	
7	6	6 6 6 6 6 6	
8	7	7 7 7 7 7 7	
	8 8	8 8 8 8 8 8	
	9 9	9 9 9 9 9 9	

SEQNO	RECODE	CACODE	AGE
1	0 0	0 0 0 0 0 0	
2	1 1	1 1 1 1 1 1	
3	2 2	2 2 2 2 2 2	
4	3	3 3 3 3 3 3	
5	4	4 4 4 4 4 4	
6	5	5 5 5 5 5 5	
7	6	6 6 6 6 6 6	
8	7	7 7 7 7 7 7	
	8 8	8 8 8 8 8 8	
	9 9	9 9 9 9 9 9	

Item 30 Cancer Types

SEQNO	CACODE	AGE
1	0 0 0	0 0
2	1 1	1 1
3	2 2	2 2
4	3 3	3 3
5	4 4	4 4
6	5 5	5 5
7	6 6	6 6
8	7 7	7 7
	8 8 8	8
	9 9 9	9

SEQNO	CACODE	AGE
1	0 0 0	0 0
2	1 1	1 1
3	2 2	2 2
4	3 3	3 3
5	4 4	4 4
6	5 5	5 5
7	6 6	6 6
8	7 7	7 7
	8 8 8	8
	9 9 9	9

SEQNO	CACODE	AGE
1	0 0 0	0 0
2	1 1	1 1
3	2 2	2 2
4	3 3	3 3
5	4 4	4 4
6	5 5	5 5
7	6 6	6 6
8	7 7	7 7
	8 8 8	8
	9 9 9	9

SEQNO	CACODE	AGE
1	0 0 0	0 0
2	1 1	1 1
3	2 2	2 2
4	3 3	3 3
5	4 4	4 4
6	5 5	5 5
7	6 6	6 6
8	7 7	7 7
	8 8 8	8
	9 9 9	9

SEQNO	CACODE	AGE
1	0 0 0	0 0
2	1 1	1 1
3	2 2	2 2
4	3 3	3 3
5	4 4	4 4
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7	6 6	6 6
8	7 7	7 7
	8 8 8	8
	9 9 9	9

SEQNO	CACODE	AGE
1	0 0 0	0 0
2	1 1	1 1
3	2 2	2 2
4	3 3	3 3
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7	6 6	6 6
8	7 7	7 7
	8 8 8	8
	9 9 9	9

SEQNO	CACODE	AGE
1	0 0 0	0 0
2	1 1	1 1
3	2 2	2 2
4	3 3	3 3
5	4 4	4 4
6	5 5	5 5
7	6 6	6 6
8	7 7	7 7
	8 8 8	8
	9 9 9	9

SEQNO	CACODE	AGE
1	0 0 0	0 0
2	1 1	1 1
3	2 2	2 2
4	3 3	3 3
5	4 4	4 4
6	5 5	5 5
7	6 6	6 6
8	7 7	7 7
	8 8 8	8
	9 9 9	9

PLEASE DO NOT WRITE IN THIS AREA



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